action is not a significant regulatory action under Executive Order 12866.

I. National Technology Transfer and Advancement Act (NTTAA)

In addition, since this action does not involve any technical standards, NTTAA section 12(d) (15 U.S.C. 272 note), does not apply to this action.

J. Executive Order 12898

This action does not entail special considerations of environmental justice related issues as delineated by Executive Order 12898, entitled ''Federal Actions to Address Environmental Justice in Minority Populations and Low-Income Populations'' (59 FR 7629, February 16, 1994).

XI. Congressional Review Act (CRA)

Pursuant to the Congressional Review Act (5 U.S.C. 801 *et seq.*), EPA will submit a report containing this rule and other required information to the U.S. Senate, the U.S. House of Representatives, and the Comptroller General of the United States prior to publication of the rule in the **Federal Register**. This action is not a ''major rule'' as defined by 5 U.S.C. 804(2).

List of Subjects

40 CFR Part 9

Environmental protection, Reporting and recordkeeping requirements.

40 CFR Part 721

Environmental protection, Chemicals, Hazardous substances, Reporting and recordkeeping requirements.

Dated: January 20, 2014.

Maria J. Doa,

Director, Chemical Control Division, Office of Pollution Prevention and Toxics.

Therefore, 40 CFR parts 9 and 721 are amended as follows:

PART 9—[AMENDED]

■ 1. The authority citation for part 9 continues to read as follows:

Authority: 7 U.S.C. 135 *et seq.,* 136–136y; 15 U.S.C. 2001, 2003, 2005, 2006, 2601–2671; 21 U.S.C. 331j, 346a, 348; 31 U.S.C. 9701; 33 U.S.C. 1251 *et seq.,* 1311, 1313d, 1314, 1318, 1321, 1326, 1330, 1342, 1344, 1345(d) and (e), 1361; E.O. 11735, 38 FR 21243, 3 CFR, 1971–1975 Comp. p. 973; 42 U.S.C. 241, 242b, 243, 246, 300f, 300g, 300g-1, 300g-2, 300g-3, 300g-4, 300g-5, 300g-6, 300j-1, 300j-2, 300j-3, 300j-4, 300j-9, 1857 *et seq.,* 6901–6992k, 7401–7671q, 7542, 9601–9657, 11023, 11048.

■ 2. In § 9.1, add the following section in numerical order under the undesignated center heading ''Significant New Uses of Chemical Substances'' to read as follows:

§ 9.1 OMB approvals under the Paperwork Reduction Act.

* * * * *

40 CFR citation	OMB Control No.
* * * * *	
Significant New Uses of Chemical Substances	
* * * * *	
721.10423	2070–0012
* * * * *	

* * * * *

PART 721—[AMENDED]

■ 3. The authority citation for part 721 continues to read as follows:

Authority: 15 U.S.C. 2604, 2607, and 2625(c).

■ 4. Add § 721.10423 to subpart E to read as follows:

§ 721.10423 Complex strontium aluminate, rare earth doped (generic).

(a) *Chemical substances and significant new uses subject to reporting.* (1) The chemical substances identified generically as complex strontium aluminate, rare earth doped (PMNs P–12–22, P–12–23, P–12–24, P–12–25, and P–12–26) are subject to reporting under this section for the significant new uses described in paragraph (a)(2) of this section.

(2) The significant new uses are:

(i) *Industrial, commercial, and consumer activities.* A significant new use of the substance is a use other than manufacture, processing, or use where no more than 5 percent of particles are less than 10 microns.

(ii) [Reserved]

(b) *Specific requirements.* The provisions of subpart A of this part apply to this section except as modified by this paragraph.

(1) *Recordkeeping.* Recordkeeping requirements as specified in § 721.125(a), (b), (c), and (i) are applicable to manufacturers, importers, and processors of this substance.

(2) *Limitations or revocation of certain notification requirements.* The provisions of § 721.185 apply to this section.

[FR Doc. 2014–02223 Filed 2–3–14; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 424

[CMS–6046–N]

Medicare, Medicaid, and Children's Health Insurance Programs: Announcement of New and Extended Temporary Moratoria on Enrollment of Ambulances and Home Health Agencies in Designated Geographic Locations

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Extension and establishment of temporary moratoria.

SUMMARY: This document announces the imposition of temporary moratoria on the enrollment of new ambulance suppliers and home health agencies in designated geographic locations to prevent and combat fraud, waste, and abuse.

DATES: Effective January 30, 2014.

FOR FURTHER INFORMATION CONTACT: August Nemec, (410) 786–0612. News media representatives must contact CMS' Public Affairs Office at (202) 690–6145 or email them at *press@cms.hhs.gov.*

SUPPLEMENTARY INFORMATION:

I. Background

A. CMS' Authority To Impose Temporary Enrollment Moratoria

Under the Patient Protection and Affordable Care Act (Pub. L. 111–148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152) (collectively known as the Affordable Care Act), the Congress provided the Secretary with new tools and resources to combat fraud, waste, and abuse in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). Section 6401(a) of the Affordable Care Act added a new section 1866(j)(7) to the Social Security Act (the Act) to provide the Secretary with authority to impose a temporary moratorium on the enrollment of new Medicare, Medicaid or CHIP providers and suppliers, including categories of providers and suppliers, if the Secretary determines a moratorium is necessary to prevent or combat fraud, waste, or abuse under these programs. Section 6401(b) of the Affordable Care Act added specific moratorium language applicable to Medicaid at section 1902(kk)(4) of the Act, requiring States to comply with any

moratorium imposed by the Secretary unless the state determines that the imposition of such moratorium would adversely impact Medicaid beneficiaries' access to care. Section 6401(c) of the Affordable Care Act amended section 2107(e)(1) of the Act to provide that all of the Medicaid provisions in sections 1902(a)(77) and 1902(kk) are also applicable to CHIP.

In the February 2, 2011 **Federal Register** (76 FR 5862), CMS published a final rule with comment period titled, ''Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers,'' which implemented section 1866(j)(7) of the Act by establishing new regulations at 42 CFR 424.570. Under § 424.570(a)(2)(i) and (iv), CMS, or CMS in consultation with the Department of Health and Human Services' Office of Inspector General (HHS–OIG) or the Department of Justice (DOJ), or both, may impose a temporary moratorium on newly enrolling Medicare providers and suppliers if CMS determines that there is a significant potential for fraud, waste, or abuse with respect to a particular provider or supplier type or particular geographic locations or both. At § 424.570(a)(1)(ii), CMS stated that it would announce any temporary moratorium in a **Federal Register** document that includes the rationale for the imposition of such moratorium. This document fulfills that requirement.

In accordance with section 1866(j)(7)(B) of the Act, there is no judicial review under sections 1869 and 1878 of the Act, or otherwise, of the decision to impose a temporary enrollment moratorium. A provider or supplier may use the existing appeal procedures at 42 CFR part 498 to administratively appeal a denial of billing privileges based on the imposition of a temporary moratorium, however the scope of any such appeal would be limited solely to assessing whether the temporary moratorium applies to the provider or supplier appealing the denial. Under § 424.570(c), CMS denies the enrollment application of a provider or supplier if the provider or supplier is subject to a moratorium. If the provider or supplier was required to pay an application fee, the application fee will be refunded if the application was denied as a result of the imposition of a temporary moratorium (see § 424.514(d)(2)(v)(C)).

B. Determination of the Need for a Moratorium

In imposing these enrollment moratoria, CMS considered both qualitative and quantitative factors suggesting a high risk of fraud, waste, or abuse. CMS relied on law enforcement's longstanding experience with ongoing and emerging fraud trends and activities through civil, criminal, and administrative investigations and prosecutions. CMS' determination of high risk fraud in these provider and supplier types within these geographic locations was then confirmed by CMS' data analysis, which relied on factors the agency identified as strong indicators of fraud risk.

Because fraud schemes are highly migratory and transitory in nature, many of CMS' program integrity authorities and anti-fraud activities are designed to allow the agency to adapt to emerging fraud in different locations. The laws and regulations governing CMS' moratoria authority give us flexibility to use any and all relevant criteria for future moratoria, and CMS may rely on additional or different criteria as the basis for future moratoria.

1. Application to Medicaid and the Children's Health Insurance Program (CHIP)

The February 2, 2011 final rule also implemented section 1902(kk)(4) of the Act, establishing new Medicaid regulations at § 455.470. Under § 455.470(a)(1) through (3), the Secretary [1] may impose a temporary moratorium, in accordance with § 424.570, on the enrollment of new providers or provider types after consulting with any affected State Medicaid agencies. The State Medicaid agency will impose a temporary moratorium on the enrollment of new providers or provider types identified by the Secretary as posing an increased risk to the Medicaid program unless the state determines that the imposition of a moratorium would adversely affect Medicaid beneficiaries' access to medical assistance and so notifies the Secretary. The final rule also implemented section 2107(e)(1)(D) of the Act by providing, at § 457.990 of the regulations, that all of the provisions that apply to Medicaid under sections 1902(a)(77) and 1902(kk) of the Act, as well as the implementing regulations, also apply to CHIP.

[1] The Secretary has delegated to CMS authority to administer Titles XVIII, XIX, and XXI of the Act. For more information, see the September 6, 1984 **Federal Register** (49 FR 35247) and the December 16, 1997 **Federal Register** (62 FR 65813).

Section 1866(j)(7) of the Act authorizes imposition of a temporary enrollment moratorium for Medicare, Medicaid, and/or CHIP, ''if the Secretary determines such moratorium is necessary to prevent or combat fraud, waste, or abuse under either such program.'' While there may be exceptions, CMS believes that generally, a category of providers or suppliers that poses a risk to the Medicare program also poses a similar risk to Medicaid and CHIP. Many of the new anti-fraud provisions in the Affordable Care Act reflect this concept of ''reciprocal risk'' in which a provider that poses a risk to one program poses a risk to the other programs. For example, section 6501 of the Affordable Care Act titled, ''Termination of Provider Participation under Medicaid if Terminated Under Medicare or Other State Plan,'' which amends section 1902(a)(39) of the Act, requires State Medicaid agencies to terminate the participation of an individual or entity if such individual or entity is terminated under Medicare or any other State Medicaid plan.[2] Additional provisions in title VI, Subtitles E and F of the Affordable Care Act also support the determination that categories of providers and suppliers pose the same risk to Medicaid as to Medicare. Section 6401(a) of the Affordable Care Act required us to establish levels of screening for categories of providers and suppliers based on the risk of fraud, waste, and abuse determined by the Secretary. Section 6401(b) of the Affordable Care Act required State Medicaid agencies to screen providers and suppliers based on the same levels established for the Medicare program. This reciprocal concept is also reflected in the Medicare moratoria regulations at § 424.570(a)(2)(ii) and (iii), which permit CMS to impose a Medicare moratorium based solely on a state imposing a Medicaid moratorium. Therefore, CMS has determined that there is a reasonable basis for concluding that a category of providers or suppliers that poses a risk to Medicare also poses a similar risk to Medicaid and CHIP, and that a moratorium in all of these programs is necessary to effectively combat this risk.

[2] Although section 6501 of Affordable Care Act does not specifically state that individuals or entities that have been terminated under Medicare or Medicaid must also be terminated from CHIP, CMS has required CHIP, through federal regulation, to take similar action regarding termination of a provider that is also terminated or had its billing privileges revoked under Medicare or any State Medicaid plan.

2. Consultation With Law Enforcement

In consultation with the HHS–OIG and the Department of Justice (DOJ), CMS identified two provider and supplier types in five geographic locations that warrant a temporary enrollment moratorium. CMS reached this determination based in part on the federal government's experience with the Health Care Fraud Prevention and Enforcement Action Team (HEAT), a joint effort between DOJ and HHS to prevent fraud, waste, and abuse in the Medicare and Medicaid programs. The Medicare Fraud Strike Force teams are a key component of HEAT and operate in nine locations nationwide.[3] Each HEAT Medicare Fraud Strike Force team combines the programmatic and administrative action capabilities of CMS, the analytic and investigative resources of the FBI and HHS–OIG, and the prosecutorial resources of DOJ's Criminal Division's Fraud Section and the United States Attorney's Offices. The Strike Force teams use advanced data analysis techniques to identify high billing levels in health care fraud hotspots so that interagency teams can target emerging or migrating schemes along with chronic fraud by criminals masquerading as health care providers or suppliers. The locations of the Strike Force teams are identified by analyzing where Medicare claims data reveal aberrant billing patterns and intelligence data analysis suggests that fraud may be occurring. The presence of a Strike Force team within or near a particular geographic area is one factor that CMS considered in identifying the locations subject to the moratoria announced in this document.

As a part of ongoing antifraud efforts, the HHS–OIG and CMS have learned that some fraud schemes are viral, meaning they replicate rapidly within communities, and that health care fraud also migrates—as law enforcement cracks down on a particular scheme, the criminals may redesign the scheme or relocate to a new geographic area.[4] As a result, CMS has determined that it is necessary to extend these moratoria beyond the target counties to bordering counties, unless otherwise noted, to prevent potentially fraudulent providers and suppliers from enrolling in a neighboring county with the intent of providing services in a moratorium-targeted area. CMS will monitor the surrounding counties, as well as the entirety of each affected state, by reviewing claims utilization and activity, for indicia of activity designed to evade these moratoria. Throughout the duration of these moratoria, CMS will continue to consult with law enforcement, to assess and address the spread of any significant risk of fraud beyond the moratoria locations.

3. Data Analysis

CMS analyzed its own data to determine the extent to which it confirms the specific provider and supplier types within geographic locations recommended by law enforcement as having a significant potential for fraud, waste or abuse, and therefore warranting the imposition of enrollment moratoria. CMS identified all counties across the nation with 200,000 or more Medicare beneficiaries (''comparison counties''), and analyzed certain key metrics, which we believe to be strong indicators of potential fraud risk. These metrics included factors such as the number of providers or suppliers per 10,000 Medicare fee-for-service (FFS) beneficiaries and the compounded annual growth rate in provider or supplier enrollments. CMS also reviewed the 2012 FFS Medicare payments to providers and suppliers in the target locations based on the average amount spent per beneficiary who used services furnished by the targeted provider and supplier types.

The four locations subject to the temporary enrollment moratoria for home health agencies (HHAs) are counties that contain or are adjacent to HEAT Medicare Fraud Strike Force locations and are also consistently ranked near the top for the identified metrics among counties with at least 200,000 Medicare beneficiaries in 2012. See Table 1 of this document for a summary of the moratoria locations and some of the metrics examined.

4. Beneficiary Access To Care

Beneficiary access to care in Medicare, Medicaid, and CHIP is of critical importance to CMS and its state partners, and CMS carefully evaluated access for the five target moratorium locations. To determine if the moratoria would create an access to care issue for Medicaid and CHIP beneficiaries in the targeted locations and surrounding counties, CMS consulted with the appropriate State Medicaid Agencies and with the appropriate State Department of Emergency Medical Services. All of CMS' state partners were supportive of CMS analysis and proposals, and together with CMS, have determined that these moratoria will not create access to care issues for Medicaid or CHIP beneficiaries.

In order to determine if the moratoria would create an access to care issue for Medicare beneficiaries, CMS reviewed its own data regarding the number of providers and suppliers in the target and surrounding counties, and confirmed that there are no reports to CMS of access to care issues for these provider and supplier types. This conclusion is also supported by recent reports issued by the Medicare Payment Advisory Commission (MedPAC), an independent Congressional agency established by the Balanced Budget Act of 1997 to advise Congress on issues affecting the Medicare program. MedPAC has a Congressional mandate to monitor beneficiaries' access to care and publishes its review of Medicare expenditures annually. Based on MedPAC's March 2013 report (finding no access issues to Medicare home health services [5]), and its June 2013 report (finding no access issues to Medicare ambulance services [6]), CMS does not believe these moratoria will cause an access to care issue for Medicare beneficiaries.

In the March 2013 report, MedPAC also recommended that CMS use its authorities under current law to examine providers with aberrant patterns of utilization for possible fraud and abuse. With regard to home health services, MedPAC stated that a moratorium on the enrollment of new HHAs would prevent new agencies from entering markets that may already be saturated.[7] CMS will continuously monitor for reductions in the number of HHA providers and Part B ambulance suppliers, as well as beneficiary complaints, and will continue consultation with the states, for any indication of a potential access to care issue.

5. When a Temporary Moratorium Does Not Apply

Under § 424.570(a)(1)(iii), a temporary moratorium does not apply to changes in practice locations, changes to provider or supplier information such as phone number, address, or changes in ownership (except changes in

[3] The HEAT Medicare Strike Force operates in Miami, FL; Los Angeles, CA: Detroit, MI; Houston, TX; Brooklyn, NY; Southern Louisiana (the Strike Force in Southern Louisiana started in Baton Rouge and now operates in New Orleans as well); Tampa, FL; Chicago, IL; and Dallas, TX.

[4] Testimony of the Inspector General, ''Preventing Health Care Fraud: New Tools and Approaches to Combat Old Challenges.'' See *http://www.hhs.gov/asl/testify/2011/03/t20110302i.html.*

[5] MedPAC, March 2013, ''Report to Congress: Medicare Payment Policy, Chapter 9 home health services.'' *http://www.medpac.gov/documents/Mar13_entirereport.pdf.*

[6] MedPAC, June 2013, ''Chapter 7, Mandated Report: Medicare payment for ambulance services.'' *http://www.medpac.gov/chapters/Jun13_Ch07.pdf.*

[7] MedPAC, March 2013, ''Report to Congress: Medicare Payment Policy, Chapter 9 home health services.'' *http://www.medpac.gov/documents/Mar13_entirereport.pdf.*

ownership of HHAs that require initial enrollments under § 424.550). Also, in accordance with § 424.570(a)(1)(iv), the moratorium does not apply to an enrollment application that a CMS contractor has already approved, but has not yet entered into the Provider Enrollment Chain and Ownership System (PECOS) at the time the moratorium is imposed.

6. Lifting a Temporary Moratorium

In accordance with § 424.570(b), a temporary enrollment moratorium imposed by CMS will remain in effect for 6 months. If CMS deems it necessary, the moratorium may be extended in 6-month increments. CMS will evaluate whether to extend or lift the moratorium before the end of the initial 6-month period and, if applicable, any subsequent moratorium periods. If one or more of the moratoria announced in this document are extended, CMS will publish document of such extensions in the **Federal Register**.

As provided in § 424.570(d), CMS may lift a moratorium at any time if the President declares an area a disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, if circumstances warranting the imposition of a moratorium have abated, if the Secretary has declared a public health emergency, or if in the judgment of the Secretary, the moratorium is no longer needed.

Once a moratorium is lifted, the provider or supplier types that were unable to enroll because of the moratorium will be designated to CMS' high screening level under §§ 424.518(c)(3)(iii) and 455.450(e)(2) for 6 months from the date the moratorium was lifted.

II. Imposition of Home Health Moratoria—Geographic Locations

Under its authority at § 424.570(a)(2)(i) and (iv), CMS is implementing temporary moratoria on the Medicare enrollment of HHAs in the geographic locations discussed in this section. Under regulations at §§ 455.470 and 457.990, these moratoria will also apply to the enrollment of HHAs in Medicaid and CHIP.

A. Moratorium on Enrollment of HHAs in the Florida County of Broward

CMS has determined that there are factors in place that warrant the imposition of a temporary Medicare enrollment moratorium for HHAs in Broward County (which contains the City of Fort Lauderdale, FL). Florida has divided the state into 11 home health ''licensing districts,'' that prevent an HHA from providing services outside its own licensing district. Broward is the only county in its licensing district. In this instance, it is not necessary to extend the moratorium to the other counties that border Broward because of the state's home health licensing rules that prevent providers enrolling in these counties from serving beneficiaries in Broward. CMS has also consulted with the State Medicaid Agency and reviewed available data, and determined that the moratorium will also apply to Medicaid and CHIP.

Beginning on the effective date of this document, no new HHAs will be enrolled into Medicare, Medicaid or CHIP with a practice location in the Florida county of Broward, unless their enrollment application has already been approved, but not yet entered into PECOS or the State Provider/Supplier Enrollment System at the time the moratorium is imposed.

1. Consultation With Law Enforcement

Consistent with § 424.570(a)(2)(iv), CMS has consulted with both the HHS–OIG and DOJ regarding the imposition of a moratorium on new HHAs in Broward County. Both HHS–OIG and DOJ agree that a significant potential for fraud, waste, or abuse exists with respect to HHAs in the affected geographic location. Miami-Dade, which is adjacent to Broward, is a Strike Force location. CMS has identified these counties as the target of program integrity special projects, and beneficiaries that reside in these counties are the recipients of monthly Medicare Summary Notices due to the high risk of fraud in these counties.[8] The HHS–OIG has previously identified Florida as a state that had a high percentage of HHAs with questionable billing.[9] There has also been considerable Strike Force and law enforcement activity in this area of the country. In FYs 2012 and 2013, the U.S. Attorney's Office for the Southern District of Florida charged 113 defendants in 51 HHA cases, 55 individuals pled guilty, and there have been 8 trial convictions, including cases that involved conduct in Broward. In addition to criminal prosecutions, the government has also pursued civil fraud enforcement, such as its intervention in July 2013 in a whistleblower lawsuit against a home health care company in Fort Lauderdale, alleging that the company was engaged in a multi-million dollar kickback scheme.[10] CMS program integrity contractors are also actively investigating HHAs in this area.

2. Data Analysis

a. Medicare Data Analysis

CMS' data show that in 2012, there were 31 U.S. counties nationally, including Broward, with at least 200,000 Medicare beneficiaries. CMS excluded Broward County, FL, New York County, NY, Miami-Dade County, FL and Cook County, IL, and used the remaining 27 counties as ''comparison counties.'' [11] In the comparison counties, there was an average of 5.9 HHAs per 10,000 Medicare FFS beneficiaries. In Broward County, there were 11.2 HHAs per 10,000 Medicare FFS beneficiaries. This means that the ratio of HHAs to Medicare FFS beneficiaries was 89.8 percent greater in Broward County than in the comparison counties. Broward had the fifth highest ratio of providers, behind locations all also subject to moratoria on HHA enrollment.[12]

CMS' data show that in 2012, HHAs in Broward County were receiving payments of $6,432 per average Medicare home health user per year, compared to HHAs in the comparison counties, which received payments of $5,387. Payments to HHAs in Broward were 19 percent greater than the average for the comparison counties. Broward had the sixth highest payments to

[8] HHS and DOJ, ''Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2012.'' See *http://oig.hhs.gov/publications/docs/hcfac/hcfacreport2012.pdf.*

[9] Office of Inspector General Report, ''CMS and Contractor Oversight of Home Health Agencies.'' (OEI–04–11–00220). See *https://oig.hhs.gov/oei/reports/oei-04-11-00220.pdf.* The HHS–OIG defines an ''HHA fraud-prone area'' as those that are—(1) Strike Force Cities; (2) Strike Force cities where individuals have been charged with billing potentially fraudulent home health services; and (3) located in a state that had a high percentage of HHAs with questionable billing identified by the HHS–OIG.

[10] Department of Justice, ''US Intervenes in False Claims Act Lawsuit Against Fla. Home Health Care Company and Its Owner.'' See *http://www.justice.gov/opa/pr/2013/July/13-civ-717.html.*

[11] CMS's data shows that there are 31 counties that have at least 200,000 Medicare beneficiaries. For the home health analysis, 27 ''comparison counties'' are used. Besides Broward, three other counties were excluded from the comparison counties. New York County, NY, is excluded due to unique local conditions, such as that location's high density, its compact geography, its high real estate costs, and the fact that very few HHAs that serve the large number of beneficiaries in that location are actually located within New York County. We believe that this outlier would have biased the average by making it artificially low, and could potentially over-represent the difference in ratios between the target county and the comparison counties. Miami-Dade County, FL and Cook County, IL are also excluded because CMS already determined that the data and other factors indicated a risk of fraud in those counties, and imposed HHA moratoria there on July 30, 2013, which are being extended by way of this document.

[12] The areas with the highest ratio of providers to Medicare FFS beneficiaries are: Miami-Dade County, FL; Dallas County, TX; Harris County, TX; and Oakland County, MI.

HHAs, behind locations all also subject to the moratoria on HHA enrollment.[13]

b. Medicaid Data Analysis

As discussed previously in section I.B.1. of this document, CMS believes that generally, a category of providers or suppliers that poses a risk to the Medicare program also poses a similar risk to Medicaid and CHIP. In addition, the data also show a significantly higher annual utilization of Medicaid home health services in Broward County compared to the entire state. CMS compared Broward County against the rest of the state rather than against comparison counties nationally because Medicaid policies are not necessarily uniform across different states. In 2011 [14] in Broward County, Medicaid paid HHAs an average of $281,609 per provider per year, or 95 percent more than the average of $144,704 that Medicaid paid to HHAs in the rest of the state.

3. Beneficiary Access to Care

Based upon CMS' consultation with the State Medicaid agency, CMS has concluded that imposing this temporary moratorium will not create an access to care issue for Medicaid or CHIP beneficiaries in Broward at this time. Accordingly, under §§ 455.470 and 457.990, this moratorium will apply to the enrollment of HHAs in Medicaid and CHIP, unless the State later determines that imposition of the moratorium will adversely impact beneficiary access to care and so notifies CMS under § 455.470(a)(3).

CMS reviewed Medicare data for the target county, and found that there are no problems with access to HHAs in Broward. Additionally, as described in section I.B.4. of this document, MedPAC has not reported any problems with Medicare beneficiary access to home health care. While CMS has determined there are no access to care issues for Medicare beneficiaries, nevertheless, the agency will continuously monitor these locations under a moratorium for changes such as an increase in beneficiary complaints to ensure that no access to care issues arise in the future.

B. Moratorium on Enrollment of HHAs in the Texas Counties of Dallas, Collin, Denton, Ellis, Kaufman, Rockwall, and Tarrant

CMS has determined there are factors in place that warrant the imposition of a temporary enrollment moratorium for HHAs in Dallas County, TX (which contains the City of Dallas), as well as the six surrounding Texas counties—Collin, Denton, Ellis, Kaufman, Rockwall, and Tarrant. CMS has determined that it is necessary to extend this moratorium to the surrounding counties to prevent potentially fraudulent HHAs from enrolling in a neighboring county to avoid the moratorium. CMS has consulted with the State Medicaid agency and reviewed available data and determined that this moratorium will also apply to Medicaid and CHIP.

Beginning on the effective date of this document, no new HHAs will be enrolled into Medicare, Medicaid or CHIP with a practice location in the Texas Counties of Dallas, Collin, Denton, Ellis, Kaufman, Rockwall, and Tarrant unless their enrollment application has already been approved but not yet entered into PECOS or the State Provider/Supplier Enrollment System at the time the moratorium is imposed.

1. Consultation With Law Enforcement

Consistent with § 424.570(a)(2)(iv), CMS has consulted with both the HHS–OIG and DOJ regarding the imposition of a moratorium on new HHAs in Dallas County, TX and the surrounding counties. Both HHS–OIG and DOJ agree that a significant potential for fraud, waste, or abuse exists with respect to HHAs in the affected geographic locations. The HHS–OIG has previously identified Dallas, TX as an HHA fraud-prone area because it is a Strike Force location where individuals have been charged with billing potentially fraudulent home health services, and is located in a State that had a high percentage of HHAs with questionable billing identified by the OIG.[15] There has also been considerable Strike Force and law enforcement activity in this area of the country. Since February 2011, the Strike Force has filed 4 home health fraud cases, and charged 18 individuals that have resulted in 7 guilty pleas in Dallas county TX. For example, in February 2013, two owners of a Dallas, TX home health care agency, were sentenced to 37 months in federal prison for their roles in a nearly $1.3 million health care fraud conspiracy.[16] In October 2012, a Dallas, TX area home health services company owner admitted his role in a $374 million home health fraud scheme in which he and others conspired to bill Medicare for unnecessary services that were never performed.[17] In February 2012, a Federal grand jury indicted a Dallas, TX area doctor and owner of an association of health care providers, along with five others, in a $374 million home health care fraud scheme, the largest fraud case ever indicted in terms of the amount of loss charged against a single doctor.[18]

2. Data Analysis

a. Medicare Data Analysis

CMS' data show that in 2012, there were 31 U.S. counties nationally, including Dallas, TX, with at least 200,000 Medicare beneficiaries. CMS excluded Dallas County, TX and three other counties as explained previously and used the remaining 27 counties as ''comparison counties.'' [19] In 2012, there was an average of 5.2 HHAs per 10,000 FFS beneficiaries in the comparison counties. In Dallas County, TX, there were 24.4 HHAs per 10,000 Medicare FFS beneficiaries. This means that the ratio of HHAs to FFS beneficiaries was 369 percent greater in Dallas County, TX than in the comparison counties. Only Miami-Dade County, FL had a higher ratio of HHAs to Medicare FFS beneficiaries compared to the comparison counties.

CMS' data show that in 2012, HHAs in Dallas County, TX were receiving payments of $7,336 per average home health user per year, compared to HHAs in the comparison counties, which received payments of $5,312. Payments to HHAs in Dallas County, TX were 38 percent higher than the average for HHAs in the comparison counties in 2012. Only payments in the counties of Miami-Dade, FL and Harris, TX (which contains the City of Houston) were higher in 2012.

[13] The areas with the highest payments providers to Medicare FFS are: Miami-Dade County, FL; Harris County, TX; Dallas County, TX; Tarrant County, TX; and Cook County, IL.

[14] CMS used 2011 data from the Medicaid Statistical Information System (MSIS) because it was the most recent data available for all three states in this document.

[15] Office of Inspector General Report, ''CMS and Contractor Oversight of Home Health Agencies.'' (OEI–04–11–00220). See *https://oig.hhs.gov/oei/reports/oei-04-11-00220.pdf.*

[16] DOJ, ''Local Home Health Agency Owners are sentenced for Roles in Nearly $1.3 million Health Care Fraud Conspiracy.'' See *http://www.justice.gov/usao/txn/PressRelease/2013/FEB2013/feb21opurum_george_agatha_hcf_sen.html.*

[17] DOJ, ''Owners of Texas Home Health Services Company Pleads Guilty, Admits Role in $374 million fraud scheme.'' See *http://www.fbi.gov/dallas/press-releases/2012/owner-of-texas-home-health-services-company-pleads-guilty-admits-role-in-374-million-fraud-scheme.*

[18] HHS and DOJ, ''Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2012.'' See *http://oig.hhs.gov/publications/docs/hcfac/hcfacreport2012.pdf.*

[19] See footnote 11 for explanation of the 3 additional counties that were excluded for purposes of the HHA comparison county analysis.

b. Medicaid Data Analysis

As discussed previously in section I.B.1. of this document, CMS believes that generally, a category of providers or suppliers that poses a risk to the Medicare program also poses a similar risk to Medicaid and CHIP. In addition, the data also show a significantly higher annual utilization of Medicaid home health services in Dallas County, TX compared to the entire state. CMS compared Dallas County, TX against the rest of the state rather than against comparison counties nationally because Medicaid policies are not necessarily uniform across different states. In 2011 [20] in Dallas County, TX Medicaid spent an average of $3,236 per home health user per year, or 35 percent more than the average $2,404 per home health user that Medicaid spent in the rest of the state.

3. Beneficiary Access

Based upon CMS' consultation with the State Medicaid agency, CMS has concluded that imposing this temporary moratorium will not create an access to care issue for Medicaid or CHIP beneficiaries in Dallas, TX or the surrounding counties at this time. Accordingly, under §§ 455.470 and 457.990, this moratorium will apply to the enrollment of HHAs in Medicaid and CHIP, unless the State later determines that imposition of the moratorium will adversely impact beneficiary access to care and so notifies CMS under § 455.470(a)(3).

CMS reviewed Medicare data for the target and surrounding counties, and found that there are no problems with access to HHAs in Dallas, TX or surrounding counties. Additionally, as described in section I.B.4 of this document, MedPAC has not reported any problems with Medicare beneficiary access to home health care. While CMS has determined there are no access to care issues for Medicare beneficiaries, nevertheless, the agency will continuously monitor these locations under a moratorium for changes, such as an increase in beneficiary complaints, to ensure that no access to care issues arise in the future.

C. Moratorium on Enrollment of HHAs in the Texas Counties of Harris, Brazoria, Chambers, Fort Bend, Galveston, Liberty, Montgomery, and Waller

CMS has determined that the imposition of a temporary enrollment moratorium for HHAs that enroll in Medicare, Medicaid or CHIP in Harris County, TX (which contains the City of Houston) is warranted, and is extending the moratorium to the seven surrounding counties—Brazoria, Chambers, Fort Bend, Galveston, Liberty, Montgomery, and Waller. CMS has determined that it is necessary to extend this moratorium to the surrounding counties to prevent potentially fraudulent HHAs from enrolling in a neighboring county to avoid the moratorium. CMS has also consulted with the State Medicaid Agency and reviewed available data and has determined that the moratorium will also apply to Medicaid and CHIP.

Beginning on the effective date of this document, no new HHAs will be enrolled into Medicare, Medicaid or CHIP with a practice location in the Texas Counties of Harris, Brazoria, Chambers, Fort Bend, Galveston, Liberty, Montgomery or Waller unless their enrollment application has already been approved, but not yet entered into PECOS or the State Provider/Supplier Enrollment System at the time the moratorium is imposed.

1. Consultation With Law Enforcement

Consistent with § 424.570(a)(2)(iv), CMS has consulted with both the HHS–OIG and DOJ regarding the imposition of a moratorium on new Medicare, Medicaid or CHIP HHAs in Harris County, TX and surrounding counties. Both the HHS–OIG and DOJ agree that a significant potential for fraud, waste or abuse exists with respect to HHAs in the affected geographic locations. The HHS–OIG has previously identified Houston as an HHA fraud-prone area because it is a Strike Force location where individuals have been charged with billing potentially fraudulent home health services, and is located in a State that had a high percentage of HHAs with questionable billing identified by the OIG.[21] There has also been considerable Strike Force and law enforcement activity in this area of the country. Since June 2010, the HEAT Strike Force has filed 7 cases in Houston, TX alleging home health fraud, and 16 individuals have been charged in connection with these cases resulting in 9 guilty pleas and 3 trial conviction. For example, in March 2013, a physician was sentenced to 63 months in prison for his role in a $17.3 million Medicare home health care fraud scheme.[22] In June 2012, former co-owners of a home health care company were sentenced to 9 years in prison for their participation in a $5.2 million fraud scheme.[23]

2. Data Analysis

a. Medicare Data Analysis

CMS' data show that in 2012, there were 31 U.S. counties nationally, including Harris County, TX with at least 200,000 Medicare beneficiaries. CMS excluded Harris County, TX and three other counties as explained previously and used the remaining 27 counties as ''comparison counties.'' [24] In the comparison counties in 2012, there was an average of 5.2 HHAs per 10,000 Medicare FFS beneficiaries. In Harris County, TX, there were 19.6 HHAs per 10,000 Medicare FFS beneficiaries. This means that the ratio of HHAs to Medicare FFS beneficiaries was 277 percent greater in Harris County, TX than in the comparison counties. Harris County, TX had the third highest ratio of HHAs to Medicare FFS beneficiaries compared to the comparison counties, behind Miami-Dade, FL and Dallas, TX counties.

CMS' data show that in 2012, HHAs in Harris County, TX were receiving payments of $7,631 per average home health user per year, compared to HHAs in the comparison counties, which received payments of $5,253. Payments to HHAs in Dallas County, TX were 45 percent higher than the average for HHAs in comparison counties in 2012, second only to Miami-Dade, FL.

b. Medicaid Data Analysis

As discussed previously in section I.B.1. of this document, CMS believes that generally, a category of providers or suppliers that poses a risk to the Medicare program also poses a similar risk to Medicaid and CHIP. In addition, the data also show a significantly higher annual utilization of Medicaid home health services in Harris County, TX compared to the entire state. CMS compared Harris County, TX against the rest of the state rather than against comparison counties nationally because Medicaid policies are not necessarily uniform across different states. In

[20] CMS used 2011 data from the Medicaid Statistical Information System (MSIS) because it was the most recent data available for all three states in this document.

[21] Office of Inspector General Report, ''CMS and Contractor Oversight of Home Health Agencies.'' (OEI–04–11–00220). See *https://oig.hhs.gov/oei/reports/oei-04-11-00220.pdf.*

[22] Department of Justice, ''Houston-area Doctor Sentenced to 63 months in Prison for Role in $17.3 Million Medicare Fraud Scheme.'' See *http://www.justice.gov/opa/pr/2013/March/13-crm-313.html.*

[23] HHS and DOJ, ''Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2012.'' See *http://oig.hhs.gov/publications/docs/hcfac/hcfacreport2012.pdf.*

[24] See footnote 11 for explanation of the 3 additional counties that were excluded for purposes of the HHA comparison county analysis.

2011 [25] in Harris County, TX Medicaid spent an average of $4,251 per home health user per year, or 83 percent more than the average of $2,324 per home health user that Medicaid spent in the rest of the state.

3. Beneficiary Access

Based upon CMS' consultation with the State Medicaid agency, CMS has concluded that imposing this temporary moratorium will not create an access to care issue for Medicaid or CHIP beneficiaries in Harris County, TX or the surrounding counties at this time. Accordingly, under §§ 455.470 and 457.990, this moratorium will apply to the enrollment of HHAs in Medicaid and CHIP, unless the State later determines that imposition of the moratorium will adversely impact beneficiary access to care and so notifies CMS under § 455.470(a)(3).

CMS reviewed Medicare data for the target and surrounding counties, and found that there are no problems with access to HHAs in Harris County, TX or surrounding counties. Additionally, as described in section I.B.4. of this document, MedPAC has not reported any problems with Medicare beneficiary access to home health care. While CMS has determined there are no access to care issues for Medicare beneficiaries, nevertheless, the agency will continuously monitor these locations under a moratorium for changes such as an increase in beneficiary complaints to ensure that no access to care issues arise in the future.

D. Moratorium on Enrollment of HHAs in the Michigan Counties of Wayne, Macomb, Monroe, Oakland, and Washtenaw

CMS has determined there are factors in place that warrant the imposition of a temporary enrollment moratorium for HHAs in Wayne County, MI (which contains the City of Detroit), as well as the four surrounding counties; Macomb, Monroe, Oakland, and Washtenaw. CMS has determined that it is necessary to extend this moratorium to the surrounding counties to prevent potentially fraudulent HHAs from enrolling in a neighboring county to avoid the moratorium. CMS has also consulted with the State Medicaid agency and reviewed available data and determined that the temporary moratorium will also apply to Medicaid and CHIP.

Beginning on the effective date of this document, no new HHAs will be enrolled into Medicare, Medicaid or CHIP with a practice location in the Michigan Counties of Wayne, Macomb, Monroe, Oakland, and Washtenaw unless their enrollment application has already been approved but not yet entered into PECOS or the State Provider/Supplier Enrollment System at the time the moratorium is imposed.

1. Consultation With Law Enforcement

Consistent with § 424.570(a)(2)(iv), CMS has consulted with both the HHS–OIG and DOJ regarding the imposition of a moratorium on new HHAs in Wayne County, MI and the surrounding counties. Both HHS–OIG and DOJ agree that a significant potential for fraud, waste, or abuse exists with respect to HHAs in the affected geographic locations. The HHS–OIG has previously identified Detroit has an HHA fraud-prone area because it is a Strike Force location where individuals have been charged with billing potentially fraudulent home health services, and is located in a State that had a high percentage of HHAs with questionable billing identified by the OIG.[26] There has been considerable Strike Force and law enforcement activity in this area of the country. Since January 2010, the Strike Force filed 14 home health fraud cases, and charged 84 individuals that have resulted in 44 guilty pleas and 6 trial convictions. For example, in May 2013, a Detroit-area home health care agency owner was sentenced to 60 months in prison for causing the submission of over $1 million in false and fraudulent billing to Medicare as part of a $13.8 million health care fraud conspiracy.[27] In April 2013, an employee of a Detroit medical service company pled guilty for her role in a $24 million home health care fraud scheme.[28] Also in April 2013, a federal jury in Detroit convicted the office manager of a home health agency for her participation in a $5.8 million Medicare fraud scheme.[29] As of March 2013, 44 individuals were charged in a health care fraud and drug distribution scheme that centered on an allegation that three home health agency owners would provide kickbacks, bribes, and other illegal benefits to physicians to induce them to write prescriptions for patients with Medicare, Medicaid, and private insurance.[30]

2. Data Analysis

a. Medicare Data Analysis

CMS data show that in 2012, there were 31 U.S. counties nationally, including Wayne County, MI with at least 200,000 Medicare beneficiaries. CMS excluded Wayne County, MI and three other counties as explained previously and used the remaining 27 counties as ''comparison counties.'' [31] In 2012, there was an average of 5.9 HHAs per 10,000 Medicare FFS beneficiaries in the comparison counties. In Wayne County, MI there were 7.1 HHAs per 10,000 Medicare FFS beneficiaries. This means that the ratio of HHAs to FFS beneficiaries was 19 percent greater in Wayne County, MI than in the comparison counties.

b. Medicaid Data Analysis

As discussed previously in section I.B.1. of this document, CMS believes that generally, a category of providers or suppliers that poses a risk to the Medicare program also poses a similar risk to Medicaid and CHIP. Additionally, the data also show a significantly higher annual utilization of Medicaid home health services in Wayne County, MI compared to the entire state. CMS compared Wayne County, MI against the rest of the state rather than to comparison counties nationally because Medicaid policies are not necessarily uniform across different states. In 2011 [32] in Wayne County, MI Medicaid paid HHAs an average of $26,981 per provider per year, or 24 percent more than the average of $21,842 that Medicaid paid HHAs in the rest of the state.

3. Beneficiary Access

Based upon CMS' consultation with the State Medicaid agency, CMS has concluded that imposing this temporary moratorium will not create an access to care issue for Medicaid or CHIP

[25] CMS used 2011 data from the Medicaid Statistical Information System (MSIS) because it was the most recent data available for all three states in this document.

[26] Office of Inspector General Report, ''CMS and Contractor Oversight of Home Health Agencies.'' (OEI–04–11–00220). See *https://oig.hhs.gov/oei/reports/oei-04-11-00220.pdf*.

[27] DOJ, ''Detroit Area Home Health Agency Owner Sentenced to 60 Months for Role in $13 Million Health Care Fraud Scheme.'' See *http://www.justice.gov/opa/pr/2013/May/13-crm-544.html*.

[28] Federal Bureau of Investigation, ''Detroit Home Health Company Employee Pleads Guilty to Role in Medicare Fraud Scheme.'' See *http://www.fbi.gov/detroit/press-releases/2013/detroit-home-health-company-employee-pleads-guilty-to-role-in-medicare-fraud-scheme*.

[29] DOJ, ''Detroit-Area Home Health Agency Office Manager Convicted in $5.8 million Medicare Fraud Scheme.'' See *http://www.justice.gov/opa/pr/2013/April/13-crm-443.html*.

[30] DOJ, ''Forty-Four Individuals Indicted in Health Care Fraud and Drug Distribution Scheme.'' See *http://www.justice.gov/usao/mie/news/2013/2013_3_20_stayreal.html*.

[31] See footnote 11 for explanation of the 3 additional counties that were excluded for purposes of the HHA comparison county analysis.

[32] CMS used 2011 data from the Medicaid Statistical Information System (MSIS) because it was the most recent data available for all three states in this document.

beneficiaries in Wayne County, MI or the surrounding counties at this time. Accordingly, under §§ 455.470 and 457.990, this moratorium will apply to the enrollment of HHAs in Medicaid and CHIP, unless the State later determines that imposition of the moratorium will adversely impact beneficiary access to care and so notifies CMS under § 455.470(a)(3).

CMS reviewed Medicare data for the target and surrounding counties, and found that there are no problems with access to HHAs in Wayne County, MI or surrounding counties. Additionally, as described in section I.B.4. of this document, MedPAC has not reported any problems with Medicare beneficiary access to home health care. While CMS has determined there are no access to care issues for Medicare beneficiaries, nevertheless, the agency will continuously monitor these locations under a moratorium for changes such as an increase in beneficiary complaints to ensure that no access to care issues arise in the future.

III. Imposition of Ambulance Moratorium—Geographic Area

Under its authority at § 424.570(a)(2)(i) and (iv), CMS is implementing a temporary moratorium on the Medicare Part B enrollment of ambulance suppliers in the geographic area discussed in this section. The moratorium does not apply to provider-based ambulances, which are owned and/or operated by a Medicare provider (or furnished under arrangement with a provider) such as a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, or hospice program,[33] and are not required to enroll separately as a supplier in Medicare Part B.[34]

Under regulations at §§ 455.470 and 457.990, this moratorium will also apply to the enrollment of ambulance service providers in Medicaid and CHIP. The moratorium does not apply to air ambulances attempting to enroll in Medicare, Medicaid or CHIP.

A. Moratorium on Enrollment of Ambulances in the Pennsylvania Counties of Philadelphia, Bucks, Delaware, and Montgomery, and the New Jersey Counties of Burlington, Camden, and Gloucester

CMS has determined that there are factors in place that warrant the imposition of a temporary enrollment moratorium for ambulance suppliers that enroll in Medicare Part B and ambulance providers in Medicaid and CHIP in Philadelphia County, PA (which contains the City of Philadelphia), as well as the six surrounding counties—the Pennsylvania counties of Bucks, Delaware, and Montgomery, and the New Jersey counties of Burlington, Camden, and Gloucester. CMS has determined that it is necessary to extend this moratorium to the surrounding counties to prevent potentially fraudulent ambulance suppliers from enrolling in a neighboring county to avoid the moratorium. CMS has consulted with the Pennsylvania and New Jersey State Medicaid Agencies and reviewed available data, and has determined that this moratorium will apply equally to enrollment of ambulance suppliers in Medicaid and CHIP.

Beginning on the effective date of this document, no new ambulance suppliers will be enrolled into Medicare, Medicaid or CHIP with a practice location in the Pennsylvania Counties of Philadelphia, Bucks, Delaware, and Montgomery, and the New Jersey Counties of Burlington, Camden, and Gloucester unless their enrollment application has already been approved but not yet entered into PECOS or the State Enrollment System at the time the moratorium is imposed. The moratorium does not apply to air ambulance suppliers or providers attempting to enroll in Medicare, Medicaid or CHIP.

1. Consultation With Law Enforcement

Consistent with § 424.570(a)(2)(iv), CMS has consulted with both the HHS–OIG and DOJ regarding the imposition of a moratorium on new ambulance suppliers in Philadelphia, PA and surrounding counties. Both the HHS–OIG and DOJ agree that a significant potential for fraud, waste and abuse exists with respect to ambulance suppliers in the affected geographic locations. The HHS–OIG previously found that the Medicare ambulance transport benefit may be highly vulnerable to abuse in locations with high utilization, such as Philadelphia, PA and surrounding locations DOJ prosecuted an operator of an ambulance service company, indicted in June 2012, for submitting more than $5.4 million in false claims to Medicare for medically unnecessary transportation of patients by ambulance.[35] Additionally, in April 2013, the owner of a Philadelphia ambulance supplier pled guilty to a health care fraud scheme that involved billing Medicare for ambulance services that were not medically necessary, that were not actually provided, or that were induced by illegal kickbacks.[36] Also in April 2013, seven people were charged in a $3.6 million health care scheme for unnecessary ambulance rides in Philadelphia.[37]

2. Data Analysis

a. Medicare Data Analysis

CMS' data show that in 2012, there were 31 U.S. counties nationally, including Philadelphia, PA, with at least 200,000 Medicare beneficiaries. CMS excluded Philadelphia County, PA, New York County, NY and Harris County, TX and used the remaining 28 counties as ''comparison counties.'' [38] In 2012, there was an average of 1.4 ambulance suppliers per 10,000 Medicare FFS beneficiaries in the comparison counties. In Philadelphia County, PA there were 4.8 ambulance suppliers per 10,000 Medicare FFS beneficiaries. This means that the ratio of ambulance suppliers to FFS beneficiaries was 243 percent greater in Philadelphia County, PA than in the comparison counties, the third highest ratio compared to comparison counties.

CMS' data show that the compounded average annual growth rate of ambulance suppliers in Philadelphia County, PA, is 15 times higher compared to the comparison counties'

[33] Medicare Claims Processing Manual, CMS Pub. No. 100–04, Chapter 15, ''Ambulance.'' See *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c15.pdf*.

[34] Medicare Program Integrity Manual, Chapter 15, Medicare Enrollment. See *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c15.pdf*.

[35] HHS and DOJ, ''Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2012.'' See *http://oig.hhs.gov/publications/docs/hcfac/hcfacreport2012.pdf*.

[36] DOJ, ''Owner of Brotherly Love Ambulance Pleads Guilty to $2 million Health Care Fraud Scheme.'' See *http://www.justice.gov/usao/pae/News/2013/Apr/kuranplea_release.htm*.

[37] DOJ, ''Seven Charged in Health Care Fraud Scheme.'' See *http://www.justice.gov/usao/pae/News/2013/Apr/pennchoice_release.htm*.

[38] CMS' data shows that there are 31 counties that have at least 200,000 Medicare beneficiaries. Besides Philadelphia, for the ambulance analysis, 2 additional locations were excluded leaving 28 ''comparison counties''. New York County is excluded due to unique local conditions, such as New York's high density, its compact geography, and its high real estate costs. We believe that this outlier would have biased the average by making it artificially low, and could potentially over-represent the difference in ratios between the target county and the comparison counties. Harris County, Texas is also excluded because CMS already determined that the data and other factors indicated a risk of ambulance fraud in that county, and imposed a moratorium on July 30, 2013, which is being extended in this document.

annual growth rate of 1 percent, the second highest growth rate compared to comparison counties.

CMS' data show that in 2012, ambulance suppliers in Philadelphia County, PA were receiving payments of $1,314 per average ambulance user per year, compared to ambulance suppliers in comparison counties, which received payments of $803. Payments to ambulance suppliers were 64 percent higher than the average for comparison counties, and the third highest compared to comparison counties.

b. Medicaid Data Analysis

As discussed previously in section I.B.1. of this document, CMS believes that generally, a category of providers or suppliers that poses a risk to the Medicare program also poses a similar risk to Medicaid and CHIP. In addition, the data also show a significantly higher annual utilization of Medicaid ambulance services in Philadelphia County, PA compared to the entire state. CMS compared Philadelphia County, PA against the rest of the state rather than to comparison counties nationally because Medicaid policies are not necessarily uniform across different states. In 2011 [39] in Philadelphia County, PA Medicaid paid ambulances an average of $18,254 per provider per year, or 130 percent more than the average of $7,922 that Medicaid paid ambulances in the rest of the state.

3. Beneficiary Access

After consulting with the Pennsylvania and New Jersey State Medicaid agencies and the Pennsylvania and New Jersey State Departments of Health Emergency Medical Services, and reviewing available data, CMS has concluded that imposing this temporary moratorium will not create an access to care issue for Medicaid or CHIP beneficiaries in Philadelphia County, PA or the surrounding counties at this time. Accordingly, under §§ 455.470 and 457.990, this moratorium will apply to the enrollment of ambulance providers in Medicaid and CHIP, unless either or both states later determine(s) that imposition of the moratorium will adversely impact beneficiary access to care and so notify(ies) CMS under § 455.470(a)(3).

CMS reviewed Medicare data for the target and surrounding counties, and found that there are no problems with access to ambulance suppliers in Philadelphia County, PA or surrounding counties. Additionally, as described in section I.B.4. of this document, MedPAC has not reported any problems with Medicare beneficiary access to ambulance services. While CMS has determined that this temporary moratorium will not create an access to care issue for Medicare beneficiaries in Philadelphia County, PA or the surrounding counties at this time, nevertheless, the agency will continuously monitor these locations under a moratorium for changes, such as any increase in beneficiary complaints, to ensure that no access to care issues arise in the future.

IV. Extension of Home Health Moratoria—Geographic Locations

In accordance with § 424.570(b), CMS may deem it necessary to extend the moratoria in 6-month increments. Under its authority at § 424.570(b), CMS is extending the temporary moratoria on the Medicare enrollment of HHAs in the geographic locations discussed in this section. Under regulations at §§ 455.470 and 457.990, this moratorium also applies to the enrollment of HHAs in Medicaid and CHIP. At § 424.570(b), CMS stated it would publish a **Federal Register** document announcing any extension, and this document fulfills that requirement.

A. Moratorium on Enrollment of HHAs in the Florida Counties of Miami-Dade and Monroe

In the July 31, 2013 **Federal Register** (78 FR 46340), CMS published a document announcing the imposition of a temporary moratorium on the enrollment of new HHAs in the Florida counties of Miami-Dade and Monroe, as well as the qualitative and quantitative factors that supported CMS' determination of a need for the moratorium. CMS consulted with both the HHS–OIG and DOJ regarding the extension of the moratorium on new HHAs in Miami-Dade and Monroe counties, and both HHS–OIG and DOJ agree that a significant potential for fraud, waste and abuse continues to exist in this geographic area. Law enforcement agencies continue to investigate and prosecute significant fraudulent activity relating to home health services in these counties. For example, five Miami residents were arrested for their roles in a $48 million home health scheme on September 25, 2013,[40] and three home health recruiters pled guilty for their role in the same $48 million scheme [41] on September 4 and 26, 2013.[42] Additionally, two Miami-Dade County, FL health care clinic owners pled guilty in connection with an $8 million health care fraud scheme involving a now-defunct home health care company on August 13, 2013.[43]

As stated in the July 31, 2013 **Federal Register** document, CMS' data showed that Miami-Dade County had the highest ratio of HHAs to Medicare FFS beneficiaries compared to comparison counties, as well as the highest payments to HHAs compared to comparison counties. During the first 60 days of the moratorium, CMS revoked the billing privileges of 14 HHAs, and deactivated the billing privileges of 7 HHAs in Miami-Dade, FL. CMS has also performed other actions, such as payment suspensions and revocation of provider/supplier numbers for HHAs in this target area.

As provided in § 424.570(d), CMS may lift a moratorium at any time if the President declares an area a disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, if circumstances warranting the imposition of a moratorium have abated, if the Secretary has declared a public health emergency or, if in the judgment of the Secretary, the moratorium is no longer needed. Neither Miami-Dade County nor Monroe County has been the site of a recent disaster or public health emergency. Additionally, the circumstances warranting the imposition of the moratorium have not yet abated, and CMS has determined that the moratorium is still needed as we monitor the indicators described and continue with administrative actions such as payment suspensions and revocation of provider/supplier numbers.

Based upon CMS' consultation with the State Medicaid Agency, CMS has concluded that extending this moratorium will not create an access to care issue for Medicaid or CHIP beneficiaries in Miami-Dade, FL or the surrounding county at this time. CMS also reviewed Medicare data for the target and surrounding county and found there are no problems with access to HHAs. Additionally, as described in section I.B.4. of this document, MedPAC has not reported any problems with Medicare beneficiary access to home health care. While CMS has determined there are no access to care issues for Medicare beneficiaries, nevertheless, the

[39] CMS used 2011 data from the Medicaid Statistical Information System (MSIS) because it was the most recent data available for all three states in this document.

[40] *http://www.justice.gov/opa/pr/2013/September/13-crm-1071.html.*

[41] *http://www.justice.gov/opa/pr/2013/September/13-crm-985.html.*

[42] *http://www.justice.gov/opa/pr/2013/September/13-crm-1077.html.*

[43] *http://www.fbi.gov/miami/press-releases/2013/health-care-clinic-owners-plead-guilty-in-miami-for-roles-in-8-million-health-care-fraud-scheme.*

agency will continue to monitor these locations.

As a result of the law enforcement consultation and consideration of the factors and activities described, CMS has determined that the temporary enrollment moratorium will be extended for 6 months to combat fraud in this area.

B. Moratorium on Enrollment of HHAs in the Illinois Counties of Cook, DuPage, Kane, Lake, McHenry and Will

In the July 31, 2013 **Federal Register** (78 FR 46340), CMS published a document announcing the imposition of a temporary moratorium on the enrollment of new HHAs in the Illinois Counties of Cook, DuPage, Kane, Lake, McHenry and Will, as well as the qualitative and quantitative factors that supported CMS' determination of a need of the moratorium.

CMS consulted with both the HHS–OIG and DOJ regarding the extension of the moratorium on new HHAs in Cook and surrounding counties, and both HHS–OIG and DOJ agree that a significant potential for fraud, waste and abuse continues to exist in this geographic area. We have found that law enforcement activities continue. For example, a Chicago resident was arrested in connection with an indictment in an alleged $12 million home health fraud scheme on October 29, 2013.[44] In another example, nine defendants were indicted in a Chicago home health kickback scheme on September 26, 2013.[45] The CEO of a Chicago home health company was arrested and $2.6 million in alleged fraud proceeds from various bank accounts were seized on August 27, 2013. A physician who was also involved in this same scheme was arrested.[46]

As stated in the July 31, 2013 **Federal Register** document, CMS' data showed that the growth rate in Cook County was double the national average of comparison counties, and that payments to HHAs were some of the highest nationally compared to the comparison counties. CMS has performed administrative actions, including investigations, referrals to law enforcement and payment suspensions on HHAs in this target area.

As provided in § 424.570(d), CMS may lift a moratorium at any time if the President declares an area a disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, if circumstances warranting the imposition of a moratorium have abated, if the Secretary has declared a public health emergency, or if in the judgment of the Secretary, the moratorium is no longer needed. Cook and the surrounding counties have not been the site of a recent disaster or public health emergency. Additionally, the circumstances warranting the imposition of the moratorium have not yet abated, and CMS has determined that the moratorium is still needed as we monitor the indicators described and continue with administrative actions such as payment suspensions and revocations of provider/supplier numbers.

Based upon CMS' consultation with the State Medicaid Agency, CMS concluded that extending this moratorium will not create an access to care issue for Medicaid or CHIP beneficiaries in Cook or the surrounding counties at this time. CMS also reviewed Medicare data for the target and surrounding counties and found there are no problems with access to HHAs. Additionally, as described in section I.B.4. of this document, MedPAC has not reported any problems with Medicare beneficiary access to home health care. While CMS has determined there are no access to care issues for Medicare beneficiaries, nevertheless, the agency will continue to monitor these locations.

As a result of the law enforcement consultation and consideration of the factors and activities described, CMS has determined that this temporary enrollment moratorium will be extended for 6 months to combat fraud in this area.

V. Extension of Ambulance Moratoria—Geographic Area

A. Moratorium on the Enrollment of Ambulance Suppliers and Providers in the Texas Counties of Harris, Brazoria, Chambers, Fort Bend, Galveston, Liberty, Montgomery and Waller

In the July 31, 2013 **Federal Register** (78 FR 46340), CMS published a document announcing the imposition of this temporary moratorium on the enrollment of new ambulance suppliers and providers in the Texas Counties of Harris, Brazoria, Chambers, Fort Bend, Galveston, Liberty, Montgomery and Waller, as well as the qualitative and quantitative factors that supported CMS' determination of a need of the moratorium.

CMS consulted with both the HHS–OIG and DOJ regarding the extension of the moratorium on new ambulances in Harris County, TX and surrounding counties, and both HHS–OIG and DOJ agree that a significant potential for fraud, waste and abuse continues to exist in this geographic area. For example, the owner of a Houston-based ambulance company was convicted of multiple counts of health care fraud on October 30, 2013.[47]

As stated in the July 31, 2013 **Federal Register** document, CMS' data showed that Harris County, TX had the highest ratio of ambulance suppliers to Medicare beneficiaries compared to the comparison counties, as well as having the highest number of providers not continuously billing since 2008—a strong indicator of churn (churn is a term used to describe the switching between provider numbers when a provider number is identified as being involved in fraud and abuse)—compared to the comparison counties. In the first 60 days of the moratorium, CMS has revoked the billing privileges of 15 ambulance suppliers.

As provided in § 424.570(d), CMS may lift a moratorium at any time if the President declares an area a disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, if circumstances warranting the imposition of a moratorium have abated, if the Secretary has declared a public health emergency, or if in the judgment of the Secretary, the moratorium is no longer needed. Harris County, TX and the surrounding counties have not been the site of a recent disaster or public health emergency. Additionally, the circumstances warranting the imposition of a moratorium have not yet abated, and CMS has determined that the moratorium is still needed as we monitor the indicators described and continue with administrative actions such as payment suspensions and revocations of provider/supplier numbers.

Based upon CMS' consultation with the State Medicaid Agency, CMS concluded that extending this moratorium will not create an access to care issue for Medicaid or CHIP beneficiaries in Harris County, TX or the surrounding counties at this time. CMS also reviewed Medicare data for the target and surrounding counties and found there are no problems with access to ambulance services. Additionally, as described in section I.B.4. of this document, MedPAC has not reported any problems with Medicare beneficiary

[44] *https://oig.hhs.gov/fraud/enforcement/criminal/.*

[45] *http://www.justice.gov/usao/iln/pr/chicago/2012/pr0925_01.pdf.*

[46] *http://www.fbi.gov/chicago/press-releases/2013/mobile-doctors-chicago-ceo-and-doctor-arrested-on-federal-health-care-fraud-charges.*

[47] *http://www.yourhoustonnews.com/deer_park/news/owner-of-texas-based-ambulance-service-convicted-of-health-care/article_49a3ed6e-355e-5478-aa99-8d383071d1dc.html.*

access to ambulance services. While CMS has determined there are no access to care issues for Medicare beneficiaries, nevertheless, the agency will continue to monitor these locations.

As a result of the law enforcement consultation and consideration of the factors and activities described, CMS has determined that the temporary enrollment moratorium will be extended for 6 months to combat fraud in these areas.

VI. Summary of the Moratoria Locations

CMS is executing its authority under sections 1866(j)(7), 1902(kk)(4), and 2107(e)(1)(D) of the Act to implement a moratorium in the following counties for these providers and suppliers:

TABLE 1—NEW HOME HEALTH AGENCY MORATORIA

City and State	Counties	Law enforcement activity	Medicare data (2012)	Medicaid data (2011)
Fort Lauderdale, FL	Broward	Adjacent to HEAT Miami-Dade Strike Force Location.	Ratio of HHAs to Medicare FFS Beneficiaries was 92 percent higher than Comparison Counties.	HHAs were paid 95 percent more per year compared to the rest of the state.
Detroit, MI	Macomb Monroe Oakland Washtenaw Wayne	HEAT Strike Force Location.	Compounded annual growth was almost double the national average.	HHAs were paid 24 percent more per year compared to the rest of the state.
Dallas, TX	Collin Dallas Denton Ellis Kaufman Rockwall Tarrant	HEAT Strike Force Location.	Ratio of HHAs to Medicare FFS Beneficiaries was 365 percent higher than Comparison Counties.	Spent 35 percent more per home health user compared to the rest of the state.
Houston, TX	Brazoria Chambers Fort Bend Galveston Harris Liberty Montgomery Waller	HEAT Strike Force Location.	Ratio of HHAs to Medicare FFS Beneficiaries was 276 percent higher than Comparison Counties.	Spent 83 percent more per home health user compared to the rest of the state.

TABLE 2—NEW AMBULANCE MORATORIUM

City and State	Counties	Law enforcement activity	Medicare data (2012)	Medicaid data (2011)
Philadelphia, PA	Bucks (PA) Delaware (PA) Montgomery (PA) Philadelphia (PA) Burlington (NJ) Camden (NJ) Gloucester (NJ)		Ratio of Ambulance Suppliers to Medicare FFS Beneficiaries was 232 percent higher than Comparison Counties.	Ambulances paid 130 percent more per year compared to the rest of the state.

VII. Regulatory Impact Statement

CMS has examined the impact of this document as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999) and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major regulatory actions with economically significant effects ($100 million or more in any 1 year). This document will prevent the enrollment of new home health providers and ambulance suppliers in Medicare, and ambulance providers in Medicaid and CHIP. Though savings may accrue by denying enrollments, the monetary amount cannot be quantified. After the imposition of the moratoria on July 30, 2013, 231 HHAs and 7 ambulance companies in all geographic areas affected by the moratoria had their applications denied. We have found the number of applications that are denied after 60 days declines dramatically, as most providers and suppliers will not submit applications during the moratoria period. Therefore, this document does not reach the economic threshold and thus is not considered a major action.

The RFA requires agencies to analyze options for regulatory relief of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $7.0 million to $35.5 million in any one year. Individuals and states are not included in the definition of a small entity. CMS is not preparing an analysis for the RFA because it has determined, and the Secretary certifies, that this

document will not have a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if an action may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, CMS defines a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area for Medicare payment regulations and has fewer than 100 beds. CMS is not preparing an analysis for section 1102(b) of the Act because it has determined, and the Secretary certifies, that this document will not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any regulatory action whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2013, that threshold is approximately $141 million. This document will have no consequential effect on state, local, or tribal governments or on the private sector.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed regulatory action (and subsequent final action) that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has Federalism implications. Since this document does not impose any costs on state or local governments, the requirements of Executive Order 13132 are not applicable.

In accordance with the provisions of Executive Order 12866, the Office of Management and Budget reviewed this document.

Authority: Sections 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh) and 44 U.S.C. Chapter 35; Sec. 1103 of the Social Security Act (42 U.S.C. 1302).

Dated: January 27, 2014.

Marilyn Tavenner,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2014–02166 Filed 1–30–14; 4:15 pm]

BILLING CODE 4120–01–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 660

[Docket No. 130717633–4069–02]

RIN 0648–XC772

Fisheries Off West Coast States; Coastal Pelagic Species Fisheries; Annual Specifications

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Final rule.

SUMMARY: NMFS issues this final rule to implement the annual catch limit (ACL), acceptable biological catch (ABC), annual catch target (ACT) and associated annual reference points for Pacific mackerel in the U.S. exclusive economic zone (EEZ) off the Pacific coast for the fishing season of July 1, 2013, through June 30, 2014. This final rule is implemented according to the Coastal Pelagic Species (CPS) Fishery Management Plan (FMP). The 2013/2014 ACL for Pacific mackerel is 52,358 metric tons (mt). The ACT, which will be the directed fishing harvest target, is 39,268 mt. If the fishery attains the ACT, the directed fishery will close, reserving the difference between the ACL and ACT (which is 13,089 mt) as a set aside for incidental landings in other CPS fisheries and other sources of mortality. This final rule is intended to conserve and manage the Pacific mackerel stock off the U.S. West Coast.

DATES: Effective March 6, 2014, through June 30, 2014.

FOR FURTHER INFORMATION CONTACT: Joshua Lindsay, West Coast Region, NMFS, (562) 980–4034.

SUPPLEMENTARY INFORMATION: During public meetings each year, the estimated biomass for Pacific mackerel is presented to the Pacific Fishery Management Council's (Council) CPS Management Team (Team), the Council's CPS Advisory Subpanel (Subpanel) and the Council's Scientific and Statistical Committee (SSC), where the biomass and the status of the fisheries are reviewed and discussed. The biomass estimate is then presented to the Council along with the calculated overfishing limit (OFL), acceptable biological catch (ABC), annual catch limit (ACL) and annual catch target (ACT) recommendations and comments from the Team, Subpanel and SSC. Following review by the Council and after hearing public comment, the Council adopts a biomass estimate and makes its catch level recommendations to NMFS.

The final rule will implement the 2013/2014 ACL, ACT and other annual catch reference points, including OFL and an ABC that takes into consideration uncertainty surrounding the current estimate of biomass, for Pacific mackerel in the U.S. EEZ off the Pacific coast. The CPS FMP and its implementing regulations require NMFS to set these annual catch levels for the Pacific mackerel fishery based on the annual specification framework in the FMP. For the 2013/2014 fishing season the ACL is set equal to the result of the ABC calculation. This formula is:

ABC = Biomass * Buffer * F_{MSY} * Distribution with the parameters described as follows:

1. *Biomass.* The estimated stock biomass of Pacific mackerel for the 2013/2014 management season is 272,932 mt.

2. *Buffer.* Used to addresses uncertainty in the OFL. For the 2013/2014 fishing season the buffer value is 0.913496. This is based on the Council's recommendation of a P* of 0.45 and the SSC recommended sigma of 0.72. The sigma for this year is double that used for previous years due to a higher level of uncertainty in the biomass estimate.

3. F_{MSY}. The fishing mortality rate at maximum sustainable yield (MSY) is set to 0.30.

4. *Distribution.* The average portion (currently 70%) of the total Pacific mackerel biomass that is estimated to be in the U.S. EEZ off the Pacific coast.

At the June 2013 Council meeting, the Council recommended management measures for the Pacific mackerel fishery. These management measures and catch specifications are based on the control rules established in the CPS FMP and a biomass estimate of 272,932 mt (the result of a full stock assessment that was completed in 2011 and updated based on a projection estimate for 2013). This biomass estimate was reviewed and approved by the SSC as the best available science for use in management.

In this final rule, based on recommendations from the Council's SSC and other advisory bodies, the Council recommended and NOAA Fisheries (NMFS) is implementing, an OFL of 57,316 mt, an ABC of 52,358 mt, an ACL 52,358 and an ACT of 39,268 mt for the 2013/2014 Pacific mackerel fishing season. The Pacific mackerel fishing season runs from July 1 to June 30 of the following year.

Amendment 13 (''ACL'' amendment) to the CPS FMP established a framework